Claims Clues

A Monthly Publication of the AHCCCS Claims Department | May, 2000

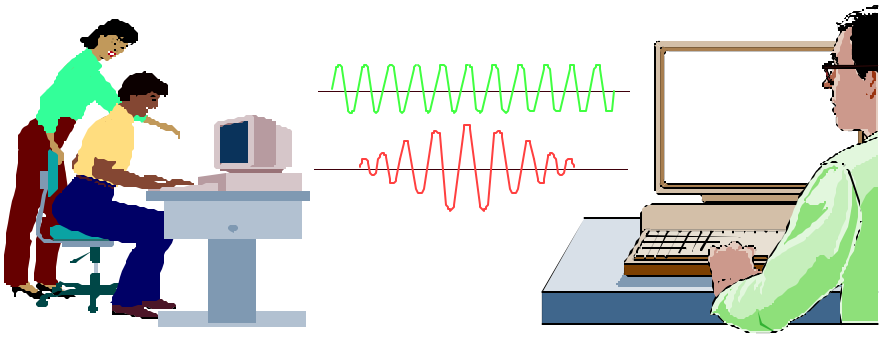
Electronic Claims Submission Hours Expanded

The hours during which providers may submit electronic claims to the AHCCCS Administration have been expanded to allow providers more opportunity to submit claims and to improve turnaround time.

Effective May 1, AHCCCS will accept electronic claims transmissions between midnight and 6:00 p.m. Monday through Thursday and between midnight and 4:00 p.m. on Fridays.

Completed transmissions received by 4:00 p.m. on Friday generally will be considered for that weekend's payment cycle.

Prior to May 1, providers could submit claims between 6:00 a.m. and 6:00 p.m. Monday though Friday.



All UB-92 and HCFA 1500 claims may be submitted electronically, regardless of the requirements for attachments (e.g., EOBs, medical documentation, etc.).

When a claim is received, the AHCCCS Claims system will determine if an attachment is required. If so, the system will generate a letter identifying the type of attachment needed to adjudicate the claim. Providers have 30 days to submit the attachments.

An *AHCCCS Electronic Claim Submission Requirements Manual* is available. For more information, providers may contact the AHCCCS Electronic Claims Submission Unit at (602) 417-4242 or (602) 417-4706. ❒

AHCCCS Begins Workers' Compensation Recovery Program

The AHCCCS third party liability contractor, Public Consulting Group Inc. (PCG), recently completed the first data match with the Industrial Commission of Arizona to identify previously unknown Workers' Compensation information for AHCCCS recipients.

The recovery process is being conducted in the same manner as the AHCCCS Medicare Disallowance Recovery Program.

PCG has identified claims paid by AHCCCS that appear to be claims that would be covered by a Workers' Compensation carrier. PCG is sending notices to the identified providers this month requesting that they submit their claims to the Workers' Compensation carrier. PCG will include in the notice to the providers the Workers' Compensation Claim Number and the name and address of the identified Workers' Compensation carrier to whom the claims should be billed.

Providers will be given 150 days to provide PCG with an EOB or other acceptable documentation that verifies the Workers' Compensation carrier's payment or denial of payment. If documentation is not received by PCG within 150 days, AHCCCS will recoup the full amount of the original AHCCCS payment.

Because this is a new recovery program and this is the first notice to providers, providers will be granted additional time for billing the Workers' Compensation carrier when the situation warrants an extension.

Questions about the new recovery program should be directed to:

Christopher Connor
Public Consulting Group, Inc.
345 Magnolia Drive
Suite A-16
Tallahassee, FL 32301

He can be reached at 1-800-973-7828 or via email at cconnor@pcgus. com. ❒

Special Handling of QMB Only Claims Ends

The AHCCCS Claims Department is no longer special handling claims for QMB Only recipients.

When AHCCCS took over the processing of fee-for-service QMB Only claims on October 1, 1999, the Claims Department began special handling these claims in order to smooth the transition for providers. These claims are now being processed in accordance with the standard procedures for all fee-for-service claims.

Providers should write "QMB Only" on the envelope and include the EOMB with the claim.

Providers should send QMB only fee-for-service claims to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

QMB Only recipients are eligible to receive Medicare-covered services only.

Chapter 7, Page 7-2 of the *AHCCCS Fee-For-Service Provider Manual* incorrectly states that AHCCCS reimburses the Medicare deductible and coinsurance for AHCCCS-covered services. The sentence should read:

"Providers are reimbursed the Medicare deductible and coinsurance for Medicare-covered services only."

Providers should make note of this change in their manuals.

Questions regarding QMB Only claims should be directed to the AHCCCS Claims Customer Service Unit at:

- Phoenix area: (602) 417-7670
- In state: 1-800-794-6862, Ext. 7670
- Out of state: 1-800-523-0231, Ext. 7670 ❒

IHS Providers Must Meet Consent Form Requirements

Indian Health Services (IHS) providers must meet the same requirements as other AHCCCS providers in order to be reimbursed for abortion, hysterectomy, and sterilization services.

Sally K. Richardson, director of HCFA's Center for Medicaid and State Operations, said in a letter to the AHCCCS Administration that IHS providers must use "the proper consent/acknowledgement form which must be received and reviewed by the Medicaid agency for compliance with the applicable statutory or regulatory requirements before payment can be made."

AHCCCS requires a completed Federal Consent Form to be submitted with claims for all voluntary sterilization procedures. A copy of the signed form must be submitted by *each provider* involved with the procedure.

A completed AHCCCS Hysterectomy Consent Form must be submitted with all claims for hysterectomy services. Providers may use a hospital consent form that contains the same information as the Hysterectomy Consent Form.

AHCCCS covers abortions only when necessary to protect the life of the mother or, for categorically eligible recipients, when the pregnancy is the result of rape or incest.

All abortions require prior authorization except in cases of medical emergency. The PA request must be accompanied by a completed Certificate of Necessity for Abortion.

In the event of an emergency, documentation of medical necessity must be provided to AHCCCS within two working days after the procedure was performed.

Chapter 5, Pages 5-25 and 5-31 of the *Native American Fee-For-Service Billing Manual* indicate that providers must keep the sterilization and hysterectomy consent forms in patient records but do not need to submit these forms with claims. Providers should update these pages to reflect the requirement to submit these forms with claims. ❒

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

Provider type 52 (MH clinic)

- End date 90889 effective 09/30/98

Provider type 72 (RBHA)

- End date W2020, W2150 - W2153, W2200, W2201, W2210, W2300, W2351 effective 09/30/98

Provider type 74 (Alternative residential facility)

- Open end W2050, W2300, W2350, W2351, Z3138, Z3140
- End date W2040 effective 01/31/00
- Add Z3139 effective 10/01/96

Provider type 77 (MH rehab)

- Open end W2100, W2400, W2402
- End date W2353 effective 06/30/99